Accompanying Families in Healing From Child Sexual Abuse and Pregnancy

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Disclosures

- Dr. Alba and Dr. Hopgood have no disclosures.

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Today's Objectives

- Understand medical and psychological risks of adolescent pregnancy
- Explore the medicolegal and ethical challenges of caring for a child/adolescent who becomes pregnant due to sexual abuse
- Review trauma-informed management strategies for the pregnant child/adolescent who has been sexually abused

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Grounding with Mindfulness

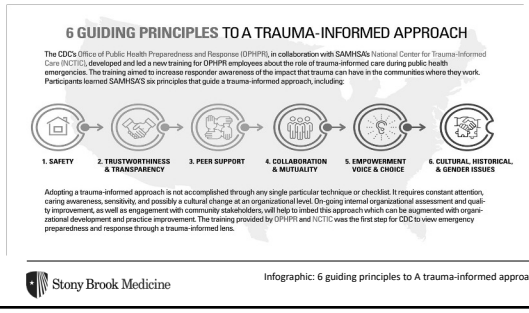
We would like to offer an opportunity to ground, which is a key practice in TIC. This is a body awareness exercise that will bring us into the present moment by directing our attention to sensations in the body. If you feel comfortable, you can close your eyes or simply relax your eyes by lowering your gaze.

- Take 5 long, deep breaths through your nose, and exhale through puckered lips.
- Place both feet flat on the floor. Wiggle your toes. Curl and uncurl your toes several times. Spend a moment noticing the sensations in your feet.
- Stomp your feet on the ground several times. Pay attention to the sensations in your feet and legs as you make contact with the ground.
- Clench your hands into fists, then release the tension. Repeat this 10 times.
- Press your palms together. Press them harder and hold this pose for 15 seconds. Pay attention to the feeling of tension in your hands and arms.
- Rub your palms together briskly. Notice and sound and the feeling of warmth.
- Reach your hands over your head like you're trying to reach the sky. Stretch like this for 5 seconds. Bring your arms down and let them relax at your sides.
- Take 5 more deep breaths and notice the feeling of calm in your body.

Now that we have grounded – we encourage you to check in with yourself throughout this presentation as we know the impact of hearing this content. We also acknowledge that many of us may have a personal connection to this topic. Breaks and pauses are encouraged.

Trauma-Informed Care

Tenets of Trauma Informed Care



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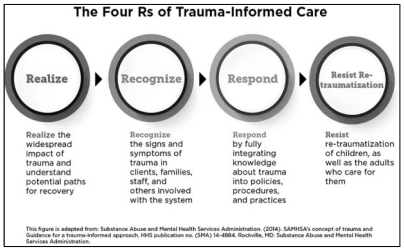
Infographic: 6 guiding principles to A trauma-informed approach, 2020

Tenets of Trauma-Informed Care



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Bartlett & Steber, 2019

Changing the Question ...

FROM "WHAT'S *WRONG* WITH YOU/YOUR PARENTS/YOUR FAMILY/YOUR COMMUNITY?"

TO "WHAT *HAPPENED* TO YOU/YOUR PARENTS/YOUR FAMILY/YOUR COMMUNITY?"

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Understanding the Impact of Childhood Sexual Abuse and Resulting Pregnancy

Global Trends in Adolescent Pregnancies

- Adolescent pregnancies are decreasing in the US and worldwide.
- Globally the birth rate for girls ages 10-14 in 2022 was estimated at 1.5 per 1000 women with higher rates in sub-Saharan Africa, Latin America and the Caribbean.
- Child marriage is a significant contributing factor for early adolescent pregnancy in developing countries.

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US Trends in Adolescent Pregnancies

- 15.4 births for every 1,000 females ages 15-19 in 2020, down 75% from the 1991 peak of 61.8.
- Decline is due to increased use of contraception by adolescents and delay in sexual debut by adolescents.
- US has one of the highest teen birth rates in industrialized nations.
- Pediatricians are likely to diagnose pregnancy in a patient given the prevalence of pregnancy in adolescence.

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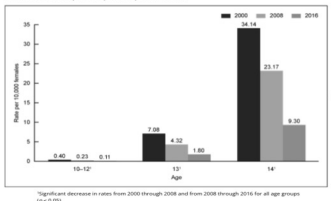
US Birth Rate Females Ages 10-14

Figure 2. Birth rates for females aged 10–12, 13, and 14: United States, 2000, 2008, and 2016



¹Significant decrease in rates from 2000 through 2008 and from 2008 through 2016 for all age groups ($p < 0.05$).
NOTE: Access data table for Figure 2.
SOURCE: NCHS, National Vital Statistics System, Natality.

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Stop & Reflect:

Notice your reactions to these statistics.

Stop & Reflect:

How Do We Define Childhood Sexual Abuse?

Developing Common Language

- Child sexual abuse occurs when a child or adolescent is engaged in sexual activities that they cannot comprehend, for which they are developmentally unprepared and are unable to give informed consent.
- Pregnancy is considered **diagnostic** of child sexual abuse.

Child Sexual Abuse and Pregnancy

- Risk of pregnancy following sexual assault estimated up to 5%.
- Pediatricians, especially CAPs, are likely to care for children and adolescents who become pregnant due to sexual abuse.
- There is a clear role for the pediatrician in the support of the patient and family in this scenario, not just the OB.

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Stop & Reflect:

Have you cared for a child or adolescent who has become pregnant due to sexual abuse?

If you answered yes, reflect on any distinction that you see your role vs. the role of the OB-GYN.

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Stop & Reflect:

How did you and your system/institution respond?

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Why is This Issue Important?

- Caring for a very young pregnant patient presents unique challenges and often moral ambiguity for the provider.
- There is a paucity of literature on the experiences of young females who become pregnant as a direct result of sexual abuse.
- The AAP and ACOG provide limited guidance on best practice for this specific scenario.
- A compassionate and conscious approach to these patients is needed.

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Risks of Adolescent Pregnancy

- Pregnant adolescents are less likely than older women to receive early and adequate prenatal care which may lead to complications.
- Continuing the pregnancy is the most common choice made by pregnant adolescents.
- Girls in early adolescence are especially vulnerable to health repercussions from pregnancy and may be physically unprepared for delivery.

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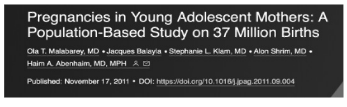
Risks of Adolescent Pregnancy


Pregnancies in Young Adolescent Mothers: A Population-Based Study on 37 Million Births

Ola T. Malabarey, MD • Jacques Balayla • Stephanie L. Klam, MD • Alon Shrim, MD • Haim A. Abenhaim, MD, MPH

Published: November 17, 2011 • DOI: https://doi.org/10.1016/j.jpag.2011.09.004

- Births to females under 15 years old were more likely to be IUGR, premature and to result in stillbirths/infant deaths.
- Pregnant females under 15 years old were less likely to have adequate prenatal care.
- Prenatal care was protective against infant deaths in females under 15 years of age.

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Psychosocial Burden of Teen Pregnancy

- About 50% of adolescent girls who have a child before 18 years of age receive a high school diploma by age 22.
- Nearly 2/3 of adolescent mothers receive public assistance, and their chances of living in poverty increase as they progress into adulthood.
- Most adolescent mothers receive no child support from their child's father.

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Psychosocial Burden of Teen Pregnancy

- The daughters of adolescent mothers are more likely to give birth as a teen.
- Children born to adolescent mothers are at a higher risk of maltreatment.
- Adolescents in foster care have a higher pregnancy rate than those who are not in foster care.

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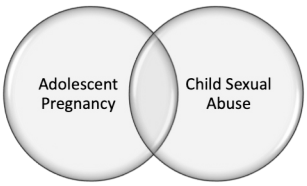
Connecting the Dots



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Unique Difficulties

- Teen pregnancy is a highly stigmatized subject as is child sexual abuse.
- Abused children worry about their bodies and worry about pregnancy--sometimes this is the reason for their disclosure.
- CSA survivors are at increased risk for negative mental health sequelae, which can be amplified with co-occurring pregnancy.
- The younger the child at age of conception, the more challenging the medical management and higher stakes of the investigation.
- Research indicates that survivors of CSA often experience revictimization during their future pregnancies.

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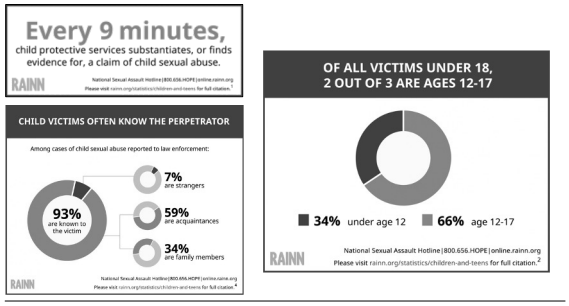
Case Presentation



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Case History

Anna is a developmentally normal, previously healthy 11-year-old female who is referred to the CAC for medical evaluation due to possible pregnancy and recent disclosure of longstanding sexual abuse by her maternal uncle. The case was initially reported to the police by the patient's mother who noted that the child had not menstruated for over 5 months. Further history provided by CPS is significant for the child making a partial disclosure of abuse to her mother many months ago with no intervention made at that time. CPS also informs you that the family's priest was made aware of the abuse history well before the police became involved. CPS informs you that the mother is supportive of the child and that there is no plan to remove Anna or her siblings from the mother's care.

Case History

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During the visit, you obtain a confidential history from the patient and determine that she is unaware of her possible pregnancy. You confirm the pregnancy at the visit on a POC urine test. You counsel the patient that she is pregnant and present all the options for her pregnancy. The patient is shocked and expresses that she is not ready to have a child, but that she knows that abortion is against her religion. You meet with the mother and child together and the mother expresses her support for the child. Both the child and mother reiterate that they are very religious. You advise that you will immediately connect the patient to OB-GYN for medical care of the pregnancy. Additional pertinent history obtained at the visit that day is significant for self-harm behavior in the child, current passive suicidal ideation, and body dysmorphia with recent disordered eating.

Two days later the patient and her mother return to your clinic. On confidential history, the child reports to you that she has decided to continue her pregnancy after much deliberation. Her mother is supportive of the decision and the mother tells you that she will raise the child as her own.

Stop & Reflect:

How would you support this patient? Would your own feelings toward her pregnancy influence how she is counseled?

Moral Distress

- Moral distress occurs as a negative emotional response when clinicians believe they know the morally correct action in patient care but are prevented from taking it because of internal/external constraints
- Perceived by the clinician as undermining professional ethical integrity
- Can be mitigated by interdisciplinary support networks
- Different from compassion fatigue, burnout

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Options Counseling and Adolescent Rights

AAP Policy Statement: Options Counseling

- Goal of leading a compassionate discussion to provide support in the decision-making process
- Expertise in family planning is not necessary
- Have patient designate a support person (trusted adult) who can be present during the discussion and throughout decision making
- Document the patient's psychosocial development and any noted limitations for abstract and future thinking
- Must be familiar with current laws impacting access to reproductive health services (abortion care)

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AAP Policy Statement: Options Counseling

- Present factually accurate information regarding all options in a non-judgmental manner, while respecting the family's spiritual, cultural, personal beliefs
- Provider should be mindful of bias and examine their own beliefs/values which can impact patient care- if conflict, ethical obligation to provide the counseling if not immediately feasible to refer to another competent provider
- Make referrals for timely prenatal care

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AAP Policy Statement: Adolescent's Right to Confidential Care

- Adolescents in the US have a right to obtain abortion without parental consent unless otherwise restricted by state law.
- The rights of adolescents to confidential care when considering abortion should be protected.
- Mandating parental involvement does not achieve the intended benefit of promoting family communication but may increase the risk of harm to the adolescent by delaying access to appropriate medical care.

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Trauma-Informed Pregnancy Care

Trauma History and Perinatal Healthcare

- For survivors of sexual violence, pregnancy and delivery can cause somatic sensations that overlap with experiences of sexual trauma.
- Medical providers can play an integral role in helping the patient reclaim the experience as affirming, healing, resilience-building.

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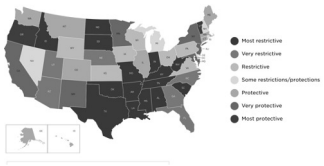
Abortion Access



Abortion policies currently in effect in New York include the following:

- Abortion is banned at fetal viability, generally 24–26 weeks of pregnancy
- State Medicaid funds cover abortion
- Private health insurance plans are required to cover abortion
- Qualified health care professionals, not solely physicians, can provide abortions
- State fund helps patients pay for abortion care
- State provides protections from harassment and physical harm for anyone entering an abortion clinic
- State has a shield law to protect abortion providers from investigations by other states; may cover patients and support organizations

Guttmacher Institute Jan 2024

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Social Determinants of Health and Trauma

Systemic inequities put children at higher risk of traumatic experiences

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Abortion Access in NY

NEW YORK STATE ABORTION LAW
FREQUENTLY ASKED QUESTIONS FOR LAW ENFORCEMENT

What type of abortion care is lawful in New York?

- New York guarantees the unqualified right to abortion up to 24 weeks after the commencement of pregnancy.
- Abortion is permitted after 24 weeks if the fetus is not viable or if the pregnant person's life or health (including mental health) is at risk.
- In New York, minors under the age of 18 may access abortion or other reproductive health services without parental notification or consent.

Are abortion services in New York confidential?

- Yes. A health care provider generally may not disclose medical records or any information about a pregnant person's appointment or procedure without their consent.
- Employers are prohibited from accessing information regarding an employee's or their partner's reproductive health decision-making.
- Under a new law effective on September 12, 2022, abortion providers, their employees, volunteers, patients, and immediate family members will be eligible to enroll in a state-run address confidentiality program if they fear for their safety or the safety of an immediate family member. See Executive Law §§ 108(1), (3).

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Termination of Pregnancy

- Balancing timeliness of TOP with patient's ability to make informed decision
- Hospital vs. Outpatient procedure: consider patient's tolerance of pain, goal of minimizing trauma
- Given the medicolegal implications of TOP, surgical procedures are preferred
- Hospital protocol for recovery of POC as evidence: maintain chain of custody
- Close follow up with OB and PMD
- Evidence-based mental health treatment
- Contraception

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Continuing Pregnancy

- Goal of establishing a safety net for mother/baby/family
- Connect patient to high quality mental health services
- Prenatal care with high-risk OB (early adolescent)
- Anticipatory guidance by OB throughout pregnancy
- Modified school plan-- minimize stigma, consider home instruction
- Medical provider must advocate for patient and future child with CPS
- Who will be primary caregiver for infant? Who is responsible for infant's daily needs? Who will provide emotional nurturance to this infant? Alternate childcare plan? How will the new baby integrate into sibling dynamic?

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Labor and Delivery

- Either NSVD or c/s acceptable: weigh medical risks/patient fear of labor/pain
- Hospital staff ideally briefed on trauma-informed care of the patient
- Maintain privacy, minimize amount of personnel interacting with the patient/changes in shift
- Routine/typical encouragement (i.e., use of mirror) may not be appropriate; use support person at bedside
- May not be a celebratory moment-- caution staff on language used in presence of patient
- Establishing breastfeeding may be challenging for very young patients-- (+/-) lactation consultant

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Postpartum Care

- Close pediatrician follow up for mother and baby-- consider enhanced well child visit schedule
- Evidence based mental health services
- Contraception
- Reintegration into school setting
- CPS surveillance and continued dialogue with the PMD
- DNA specimen obtained from infant with subpoena

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AAP Policy Statement: Care of the Adolescent Parents and Their Children

- Establish a medical home for the patient and her baby
- Provider focus on promoting nurturing relationships and positive parenting, anticipatory guidance, teaching basic caregiving skills
- Multidisciplinary and comprehensive approach through connection to community programs, home-visiting
- Encourage school completion/pursuing higher education
- Assess for DV and history of abuse
- Refer for mental health services
- Efforts should be made to support young fathers and their involvement with their children
- Contraception

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Considerations for Care

- There is a significant role that pediatricians can play in the ongoing management of the adolescent who becomes pregnant due to sexual abuse
- Consciously promote the wellbeing and resilience of the patient (and her child)
- It is not easy to care for these patients due to many ethical challenges that arise--support systems are critical
- Importance of reconciling judgement and accepting that there can be silver linings/new beginnings to this scenario

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Investigations

- The compassionate, sensitive, trauma-informed approach to CSA and pregnancy may not come naturally to some investigators
- Pediatrician/CAP can teach this approach to the investigative team
- And in doing so, become a stronger advocate for the health and wellbeing of the patient and her family, within the medical system and the investigation

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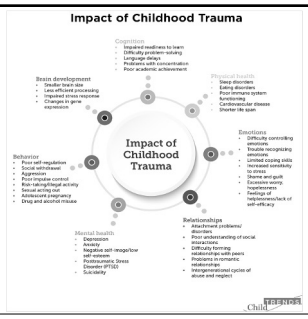
Mental Health Impact of Childhood Sexual Abuse



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Common Reactions to Childhood Sexual Abuse

Younger Children	Adolescents
• Traumatic play that includes running away from "bad people"	• Substance misuse
• Oppositional/withdrawn behavior	• Avoid traumatic reminders
• "Tantrums"	• Depression/Isolation
• Nightmares	• Avoidance of Specific Adults
• Academic decline	• Negative self-concept
• Avoidance of specific adults	• Academic decline and/or school refusal
• Age-inappropriate sexual behavior	• Issues with concentration
• Talk about their body as being "dirty" or "hurt"	• Feeling "numb" and/or irritable
• Regression (i.e., toilet training, co-sleeping, language development)	• Flashback or intrusive thoughts
• Separation anxiety	• High risk sexual behavior
• Medically unexplained body aches and pains	• Non suicidal self-injurious behaviors and suicidal behaviors

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Seshadri & Ramaswamy, 2019; About Child Trauma, n.d

Stop & Reflect:

How Do You Currently Assess And Address Possible Signs And Symptoms As The Ones Mentioned?

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"Abuse is like a boomerang. If you don't deal with it, it can come back to hurt you."

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Potential Long-term Consequences of Childhood Sexual Abuse

- Mental Health Issues
  - Posttraumatic stress disorder
  - Suicide
  - Depression
  - Anxiety
  - Substance misuse
  - Disordered eating
  - Sexual risk behavior
- Relationship Issues
  - Issues with trust, intimacy, future unstable relationships and higher divorce rates
- Sexual Dysfunction and Other Physical Health Conditions
- Revictimization
  - **50%** of childhood sexual abuse survivors experience revictimization

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Gewirtz-Meydan & Lahav, 2020; Kaplow et al., 2005; Liebschutz et al., 2002; Maniglio, 2010; Maniglio, 2013; About Child Trauma, n.d., Papalia et al., 2021; and Testa et al., 2005)

Mental Health Care of Child Sexual Abuse and Pregnancy

Children and Families Are Resilient

Protective factors, such as a child's **coping strategies** and the **availability of stable, supportive caregivers** can lessen the adverse impact of childhood sexual abuse.

Evidence-Based Therapies for Sexually Abused Children

- Cognitive Behavioral Therapies
  - Psychoeducation, Affective Modulation, Relaxation, Cognitive Restructuring, Gradual Exposure, Cognitive Processing, Narrative Sharing, Joint Parent-Child Sessions, Safety and Abuse Prevention
- NCTNS Recommendations
  - Trauma-Focused Cognitive Behavior Therapy
  - Risk Reduction through Family Therapy
  - Problematic Sexual Behavior-Cognitive-Behavioral Therapy for School-Age Children
  - Child Parent Psychotherapy

Hanson & Wallis, 2018; About Child Trauma, n.d.

Mental Health Care of Childhood Sexual Abuse Pregnancy: A Case Example

Stage 1: Stabilization and Ensuring Safety (2 Months)

- Building trust and nonjudgmental, therapeutic alliance
- Safety planning due to self-harm, suicidal ideation, and disordered eating
- Empowering parent to ensure safety
- Collaboration with other systems (legal, school, child protective services, medical)
- Assessing and affirming cultural identities (Latine background, Jehovah's Witness)
- Psychoeducation about childhood sexual abuse and pregnancy
- Exposure to sexual abuse content
- Fostering parent-child communication
- Rest and recreation
- Skill training
- Exposure/mindfulness to her body and related changes
- In-utero dyadic intervention (i.e., Reflective functioning, fantasies, fears and worries)

Stage 2: Coping Ahead for Labor (2 months)

- Increasing sense of control and agency (i.e., requesting an all-women labor team)
- Practicing guided exposure of labor and trauma reminders
- Facilitating mother and patient's communication about delivery, breast feeding, and postpartum experiences
- Determining plan for resuming daily routine and developmental activities

Mental Health Care of Childhood Sexual Abuse Pregnancy: A Case Example

Stage 3: Trauma Narration (4 Months)
- Detailing trauma
- Recurring exposure to the trauma narrative
- Narrative sharing with mother
- Outlining vision for the future

Stage 4: Dyadic Intervention (5 Months)
- Defining developmentally appropriate role and responsibilities for patient and her child
- Fostering patient-child attachment (i.e., mentalization, developmental guidance skills)
- Reorienting mother's understanding of patient's developmental tasks and support for normative developmental tasks
- Addressing trauma reminders

Stage 5: Prevention, Empowerment and End of Care (2 Months)
- Discussion of healthy relationships, consent, social support, resources
- Encouraging appropriate advocacy initiatives and using her voice
- Processing the ending with provider and family's growth

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Stop & Reflect:

Consider how you would engage in collaborative care with a mental health professional at each stage of mental health treatment. Note any barriers for interdisciplinary collaboration.

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Being Mindful of Compassion Fatigue

What is Compassion Fatigue?

Made up of ***Burnout*** (Gradual) and ***Secondary Traumatic Stress*** (Sudden and Symptom Specific)

Organizational
- Provide adequate clinical supervision, including reflective supervision
- Maintain trauma caseload balance
- Support workplace self-care groups
- Enhance the physical safety of staff
- Offer flextime scheduling
- Incorporate STS training into EBP training for clinical staff
- Create external partnerships with STS intervention providers
- Train organizational leaders and non-clinical staff on STS
- Train organizational leaders on organizational implementation and assessment
- Provide ongoing assessment of staff risk and resiliency

Individual
- Use supervision to address STS
- Increase self-awareness of STS
- Maintain healthy work-life balance
- Exercise and good nutrition
- Practice self-care
- Stay connected
- Develop and implement plans to increase personal wellness and resilience
- Continue individual training on risk reduction and self-care
- Use Employee Assistance Programs or counseling services as needed
- Participate in a self-care accountability buddy system

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Takeaways

Pause & Reflect: A Mindful End

- What are your reactions to this talk?
- How will your practice change after attending this presentation?
- Identify one action item you will bring back to your institution to promote trauma-informed care.
- Identify one way you will take care of yourself today.

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Resources

Educative Websites for All

- **https://ncsacw.samhsa.gov/resources/trauma/trauma-resource-center-websites.aspx**
- **https://www.nctsn.org/**

Trauma-informed Readings for School Staff

- What Happened to You?, Bruce Perry, MD, PhD and Oprah Winfrey
- The Body Keeps the Score, Bessel Van Der Kolk, MD
- Trauma Stewardship, Laura Van Dernoot Lipsky
- Addressing Race and Trauma in the Classroom, NCTNS
  https://www.nctsn.org/sites/default/files/resources/addressing_race_and_trauma_in_the_classroom_educators.pdf

Books/Handouts for Youth to Help Talk about Trauma and SV

- **https://www.breakingthecycles.com/blog/2019/03/21/childrens-books-to-help-talk-about-trauma-aces/**
- **https://childparentpsychotherapy.com/resources/booklists/**
- Teen Power and Control Wheel **http://www.ncdsv.org/images/teen%20p&c%20wheel%20no%20shading.pdf**
- Real Talk About Sex and Consent, Cheryl M Bradshaw, MA
- My Body Bubble: A Children's Book About Personal Boundaries, Consent and Respect, Kids Safety, Emotions and Feelings, Michael Gordon

NYS Trauma-Informed Network Organization Directory

- **https://resources.traumainformedny.org/directory**

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